

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ASC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02825

CERTIFICATE OF DEATH

Reg. Dist. No. 100

02815

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles Co</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Charles Co</i>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Laplace md</i>				TOWN <i>Laplace md</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Andrew F</i> (Middle) <i>BURCH</i> (Last)				3		20 57	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>M</i>	<i>W</i>	<i>Single</i>	<i>6-7-97</i>	<i>59</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>Auto Salesman</i>					<i>Hughesville md.</i>		<i>md & a</i>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>James W Burch</i>				<i>Emma M Carter</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
			<i>577-10-8457</i>		<i>Mr Agnes J Pearce</i>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
18. MEDICAL CERTIFICATION						3-20-57	
420. IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19..... to 19....., that I last saw the deceased alive on....., and that death occurred at..... M, from the causes and on the date stated above.							
SIGNATURE <i>E. J. Adelen</i>				M.D.		DATE SIGNED <i>3-21-57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>3-22-57</i>		<i>Cedar Hill</i>		<i>Subland md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>3/22/57</i>		<i>Julia H Posey</i>		<i>Archard Inc Laplace md</i>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Reg. Dist. No.

ST. MARY'S HOSPITAL, BALTIMORE, MARYLAND

MARYLAND

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

BUREAU V. B.

MAR 26 1957

RECEIVED

RECEIVED

NOTICE: This certificate is valid only if filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within 10 days of the date of death. It is not valid if filed in any other office.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02816

02826₁₀₀

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata, Md.		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Kenneth Last Burrell				4. DATE OF DEATH Month March Day 9 Year 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 19, 1957		9. AGE (In years last birthday) yrs. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Burrell				14. MOTHER'S MAIDEN NAME Hanett Mamie Carter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Janett Mamie Carter, La Plata, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3-8-59	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. J. Edelen</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. J. Edelen, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 3-10-57		22c. NAME OF CEMETERY OR CREMATORY Newtown Cemetery		22d. LOCATION (City, town, or county) (State) La Plata, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home				ADDRESS Waldorf, Md.		24a. RECEIVED BY REGISTRAR DATE MAR 19 1957	
				24b. REGISTRAR'S SIGNATURE <i>Julia P...</i>			

MAR 12-1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS-15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02827

02817

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Laplace</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Welcome</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Phy. Memorial Hospital</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Joseph</i>		(Middle) <i>H</i>		(Last) <i>ELDER</i>		(Month) <i>March</i> (Day) <i>9</i> (Year) <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>June 25, 1884</i>	9. AGE last birthday <i>72</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Anthony C Elder</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Darcy</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Helen Hilbert Berlin</i>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
420.0 IMMEDIATE CAUSE (A) <i>Cardiac Failure</i>							<i>4 days</i>
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis heart disease</i>							<i>10 years</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>March 9, 1957</i> , to <i>March 9, 1957</i> , that I last saw the deceased alive on <i>March 9, 1957</i> , and that death occurred at <i>9:12 PM</i> from the causes and on the date stated above.							
SIGNATURE <i>J. M. Johnson</i>		M.D.		ADDRESS (Street, city, town, state) <i>Laplace Md</i>		DATE SIGNED <i>3-10-57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3/12/57</i>		NAME OF CEMETERY OR CREMATORY <i>St Ignatius</i>		LOCATION (City, town, or county) (State) <i>Bel Clifton Md</i>	
24. REC'D BY REGISTRAR <i>3/11/57</i>		REGISTRAR'S SIGNATURE <i>Julia Hasey</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Richard Mc Laplace Md</i>		ADDRESS	

02857

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

1. DECEASED'S NAME (LAST, FIRST, MIDDLE)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF NOTARY

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF DEPUTY SHERIFF

20. SIGNATURE OF JAILER

21. SIGNATURE OF WARDEN

22. SIGNATURE OF CHIEF OF POLICE

23. SIGNATURE OF DEPUTY CHIEF OF POLICE

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF DEPUTY SHERIFF

26. SIGNATURE OF JAILER

27. SIGNATURE OF WARDEN

28. SIGNATURE OF CHIEF OF POLICE

29. SIGNATURE OF DEPUTY CHIEF OF POLICE

30. SIGNATURE OF SHERIFF

31. SIGNATURE OF DEPUTY SHERIFF

32. SIGNATURE OF JAILER

33. SIGNATURE OF WARDEN

34. SIGNATURE OF CHIEF OF POLICE

35. SIGNATURE OF DEPUTY CHIEF OF POLICE

36. SIGNATURE OF SHERIFF

37. SIGNATURE OF DEPUTY SHERIFF

38. SIGNATURE OF JAILER

39. SIGNATURE OF WARDEN

40. SIGNATURE OF CHIEF OF POLICE

41. SIGNATURE OF DEPUTY CHIEF OF POLICE

42. SIGNATURE OF SHERIFF

43. SIGNATURE OF DEPUTY SHERIFF

44. SIGNATURE OF JAILER

45. SIGNATURE OF WARDEN

BUREAU V. S.

MAR 13 1957

RECEIVED

NOTIFICATION

NOTIFICATION
The undersigned hereby certifies that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.
WITNESSED my hand and the seal of the State Department of Health, Baltimore, Maryland, this 13th day of March, 1957.
[Signature]
[Seal]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Item 9 Film 6212 3-13-57 et									
Reg. Dist. No. 02828 106									
1. PLACE OF DEATH a. COUNTY <u>Indian Head, Charles County</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Charles</u> b. COUNTY <u>Maryland</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>			c. LENGTH OF STAY IN lb <u>Six Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head X 2</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>					d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul Herbert Gibson</u>					4. DATE OF DEATH <u>3-2-57</u> Month <u>6</u> Day <u>19</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W-US</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-26-1896</u>		9. AGE (In years last birthday) <u>61</u> 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Washington County Tenn.</u>			12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
13. FATHER'S NAME <u>John Gibson</u>					14. MOTHER'S MAIDEN NAME <u>Grace Anderson</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>					16. SOCIAL SECURITY NO. <u>209-01-3829</u>		17. INFORMANT <u>Gilbert Lee Gibson (Son)</u> Address <u>1403-Strauss Ave Indian Head Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Artero Sclerosis</u> DUE TO (c) <u>Indefinite</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>				
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>James E. Andrews MD</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>James E. Andrews MD</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 6, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>					ADDRESS <u>Waldorf, Md</u>		24a. REC'D BY REGISTRAR <u>DAY 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Adey Price</u>

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR - 5 - 1957

RECEIVED

ORIGINAL FILED IN 100-100000-100000

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02819

CERTIFICATE OF DEATH

02829

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <i>Charles</i> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i> TOWN <i>La Plata</i> LENGTH OF STAY (In this place) <i>4 days</i>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md</i> COUNTY <i>Prince Georges</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Oxon Run Hill</i> TOWN <i>16X02</i> STREET ADDRESS (If rural give location) <i>5057 Dunlap</i>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>RICHARD KING Sr.</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>MAR 18 19 57</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>MAY 7, 1907</i>	9. AGE last birthday <i>49</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Naval Powder Factory</i>		11. BIRTHPLACE (State or foreign country) <i>Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Waldo D. King</i>				14. MOTHER'S MAIDEN NAME <i>Lula Thornton</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <i>Cardiac congestive failure</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary occlusion</i>				<i>4 days</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21e. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3-13</i> , 19 <i>57</i> , to <i>3-18</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>3-17</i> , 19 <i>57</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>W. W. Chambers</i>				M.D. <i>La Plata, Md.</i> ADDRESS (Street, city, town, state) <i>3-18, 57</i> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3-22-57</i>		NAME OF CEMETERY OR CREMATORY <i>Washington Natl</i>		LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>	
24. REC'D BY REGISTRAR DATE <i>MAR 22 1957</i>		REGISTRAR'S SIGNATURE <i>Julia Pacey</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers</i>		ADDRESS <i>Washington, D.C.</i>	

CERTIFICATE OF DEATH

Form D-1-54

1. PLACE OF ABODE

2. DATE OF DEATH

3. TIME OF DEATH

4. PLACE OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. EDUCATION

11. MARITAL STATUS

12. PREVIOUS ILLNESS

13. PREVIOUS SURGERY

14. PREVIOUS TRAUMA

15. PREVIOUS DRUGS

16. PREVIOUS ALCOHOL

17. PREVIOUS TOBACCO

18. PREVIOUS OTHER

19. PREVIOUS OTHER

20. PREVIOUS OTHER

21. PREVIOUS OTHER

22. PREVIOUS OTHER

23. PREVIOUS OTHER

24. PREVIOUS OTHER

25. PREVIOUS OTHER

26. PREVIOUS OTHER

27. PREVIOUS OTHER

28. PREVIOUS OTHER

29. PREVIOUS OTHER

30. PREVIOUS OTHER

1. PLACE OF ABODE

2. DATE OF DEATH

3. TIME OF DEATH

4. PLACE OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. EDUCATION

11. MARITAL STATUS

12. PREVIOUS ILLNESS

13. PREVIOUS SURGERY

14. PREVIOUS TRAUMA

15. PREVIOUS DRUGS

16. PREVIOUS ALCOHOL

17. PREVIOUS TOBACCO

18. PREVIOUS OTHER

19. PREVIOUS OTHER

20. PREVIOUS OTHER

21. PREVIOUS OTHER

22. PREVIOUS OTHER

23. PREVIOUS OTHER

24. PREVIOUS OTHER

25. PREVIOUS OTHER

26. PREVIOUS OTHER

27. PREVIOUS OTHER

28. PREVIOUS OTHER

29. PREVIOUS OTHER

1. PLACE OF ABODE

2. DATE OF DEATH

3. TIME OF DEATH

4. PLACE OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. EDUCATION

11. MARITAL STATUS

12. PREVIOUS ILLNESS

13. PREVIOUS SURGERY

14. PREVIOUS TRAUMA

15. PREVIOUS DRUGS

16. PREVIOUS ALCOHOL

17. PREVIOUS TOBACCO

18. PREVIOUS OTHER

19. PREVIOUS OTHER

20. PREVIOUS OTHER

21. PREVIOUS OTHER

22. PREVIOUS OTHER

23. PREVIOUS OTHER

24. PREVIOUS OTHER

25. PREVIOUS OTHER

26. PREVIOUS OTHER

27. PREVIOUS OTHER

28. PREVIOUS OTHER

29. PREVIOUS OTHER

1. PLACE OF ABODE

2. DATE OF DEATH

3. TIME OF DEATH

4. PLACE OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. EDUCATION

11. MARITAL STATUS

12. PREVIOUS ILLNESS

13. PREVIOUS SURGERY

14. PREVIOUS TRAUMA

15. PREVIOUS DRUGS

16. PREVIOUS ALCOHOL

17. PREVIOUS TOBACCO

18. PREVIOUS OTHER

19. PREVIOUS OTHER

20. PREVIOUS OTHER

21. PREVIOUS OTHER

22. PREVIOUS OTHER

23. PREVIOUS OTHER

24. PREVIOUS OTHER

25. PREVIOUS OTHER

26. PREVIOUS OTHER

27. PREVIOUS OTHER

28. PREVIOUS OTHER

29. PREVIOUS OTHER

1. PLACE OF ABODE

2. DATE OF DEATH

3. TIME OF DEATH

4. PLACE OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. EDUCATION

11. MARITAL STATUS

12. PREVIOUS ILLNESS

13. PREVIOUS SURGERY

14. PREVIOUS TRAUMA

15. PREVIOUS DRUGS

16. PREVIOUS ALCOHOL

17. PREVIOUS TOBACCO

18. PREVIOUS OTHER

19. PREVIOUS OTHER

20. PREVIOUS OTHER

21. PREVIOUS OTHER

22. PREVIOUS OTHER

23. PREVIOUS OTHER

24. PREVIOUS OTHER

25. PREVIOUS OTHER

26. PREVIOUS OTHER

27. PREVIOUS OTHER

28. PREVIOUS OTHER

29. PREVIOUS OTHER

RECEIVED

RECEIVED

BUREAU V. S.

MAR 22 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02830

02820

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>CHARLES</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town) TOWN <u>LA PLATA</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial</u>				STREET ADDRESS (If rural give location) <u>Ironsides</u>			
3. NAME OF DECEASED (Type or Print) <u>ERNEST WEBSTER MADDOX</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>31</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W-</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>2 May 1887</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. (BIRTH)PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WEBSTER MADDOX</u>				14. MOTHER'S MAIDEN NAME <u>MARY FRANCES COFFER COFFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-555-3986</u>		17. INFORMANT & ADDRESS <u>Mrs Arthur Maddox - Nanter</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <u>Respiratory Collapse</u>						<u>2 1/2 hr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral vascular accident</u>						<u>2 1/2 hrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive Cardio-vascular disease</u>						<u>4 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>30 Mar 1957</u>, to <u>31 Mar 1957</u>, that I last saw the deceased alive on <u>31 Mar 1957</u>, and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Howard D. M.D.</u>		DATE THEREOF <u>4/2/57</u>		NAME OF CEMETERY OR CREMATORY <u>Chicamux</u>		LOCATION (City, town, or county) <u>Chicamux, Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Julia H. Pacey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arbent Funeral Home</u>		ADDRESS <u>La Plata, Md</u>	
DATE <u>4/1/57</u>							

02880

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

REG. GEN. NO.

2. PLACE WHERE DEATH OCCURRED

RESIDENCE

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

FINAL CAUSE

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

CAUSE OF BIRTH

INTERMEDIATE CAUSE

FINAL CAUSE

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

INTERMEDIATE CAUSE

FINAL CAUSE

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

CAUSE OF BIRTH

INTERMEDIATE CAUSE

FINAL CAUSE

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

INTERMEDIATE CAUSE

FINAL CAUSE

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

CAUSE OF BIRTH

INTERMEDIATE CAUSE

FINAL CAUSE

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

INTERMEDIATE CAUSE

FINAL CAUSE

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

CAUSE OF BIRTH

INTERMEDIATE CAUSE

FINAL CAUSE

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

INTERMEDIATE CAUSE

FINAL CAUSE

BUREAU V. S.

APR 3 1957

RECEIVED

NOTIFICATION

1. Name of decedent
2. Sex
3. Race
4. Date of birth
5. Place of birth
6. Date of death
7. Place of death
8. Cause of death
9. Intermediate cause
10. Final cause
11. Place of burial
12. Date of burial
13. Time of burial
14. Cause of burial
15. Intermediate cause
16. Final cause
17. Place of death
18. Date of death
19. Time of death
20. Cause of death
21. Intermediate cause
22. Final cause
23. Place of birth
24. Date of birth
25. Time of birth
26. Cause of birth
27. Intermediate cause
28. Final cause
29. Place of death
30. Date of death
31. Time of death
32. Cause of death
33. Intermediate cause
34. Final cause
35. Place of birth
36. Date of birth
37. Time of birth
38. Cause of birth
39. Intermediate cause
40. Final cause
41. Place of death
42. Date of death
43. Time of death
44. Cause of death
45. Intermediate cause
46. Final cause
47. Place of birth
48. Date of birth
49. Time of birth
50. Cause of birth
51. Intermediate cause
52. Final cause
53. Place of death
54. Date of death
55. Time of death
56. Cause of death
57. Intermediate cause
58. Final cause
59. Place of birth
60. Date of birth
61. Time of birth
62. Cause of birth
63. Intermediate cause
64. Final cause
65. Place of death
66. Date of death
67. Time of death
68. Cause of death
69. Intermediate cause
70. Final cause
71. Place of birth
72. Date of birth
73. Time of birth
74. Cause of birth
75. Intermediate cause
76. Final cause
77. Place of death
78. Date of death
79. Time of death
80. Cause of death
81. Intermediate cause
82. Final cause
83. Place of birth
84. Date of birth
85. Time of birth
86. Cause of birth
87. Intermediate cause
88. Final cause
89. Place of death
90. Date of death
91. Time of death
92. Cause of death
93. Intermediate cause
94. Final cause
95. Place of birth
96. Date of birth
97. Time of birth
98. Cause of birth
99. Intermediate cause
100. Final cause

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Charles</u>			
CITY OR TOWN <u>La Plata</u> (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Indian Head,</u> (If outside corporate limits, write RURAL and give nearest town)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS <u>1</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Carrie H. Marshall</u>				<u>March 6 19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Dec. 19/1870</u>	
9. AGE last birthday <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		<u>House wife</u>		<u>Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME <u>Benjamin Hodges</u>				14. MOTHER'S MAIDEN NAME <u>Berganna Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8-Hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerosis General</u>				Indefinite			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>NONE</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1</u> , 19 <u>55</u> , to <u>3-6-57</u> , 19 <u> </u> , that I last saw the deceased alive on <u>3-6-57</u> , 19 <u> </u> , and that death occurred at <u>3:30 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>James E. Deane</u> M.D.				ADDRESS (Street, city, town, state) <u>17-Potomac Ave Indian Head Md.</u>		DATE SIGNED <u>3-7-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>3-9-57</u>		NAME OF CEMETERY OR CREMATORY <u>Bumpy Lake</u>		LOCATION (City, town, or county) (State) <u>Potomac Md</u>	
24. REC'D BY REGISTRAR <u>3/8/57</u>		REGISTRAR'S SIGNATURE <u>Julia H. Paser</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Prehart Inc</u>		ADDRESS <u>La Plata Md.</u>	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02832

02822

Reg. Dist. No. 100

1. PLACE OF DEATH o. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah			c. LENGTH OF STAY IN 1b 30 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Mack Robert Martin				4. DATE OF DEATH Month Day Year March 8, 1957 19				
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1889		
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter			10b. KIND OF BUSINESS OR INDUSTRY Janitor		11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Dock Martin				14. MOTHER'S MAIDEN NAME Savannah Williams				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Daughter Robbie Cheatham		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the Liver 581.1 DUE TO Chronic Alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Alcoholism DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lues							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE William J. Kurz				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) William J. Kurz M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		3-10-57		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/13/57		22c. NAME OF CEMETERY OR CRYPTORY Edgfield S.C.		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Jenkins				ADDRESS 1702-12th St & W		24a. REC'D BY REGISTRAR DATE 3/14/57		
				24b. REGISTRAR'S SIGNATURE Julia H. Pacey				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE		TIME	
DISEASE		SYMPTOMS		TREATMENT		PROGNOSIS		FINDINGS		OPINION		SIGNATURE OF EXAMINER		DATE		TIME	
HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		RADIOLOGICAL EXAMINATIONS		PATHOLOGICAL EXAMINATIONS		TOXICOLOGICAL EXAMINATIONS		SIGNATURE OF EXAMINER		DATE		TIME	
FAMILY HISTORY		SOCIAL HISTORY		PERSONAL HISTORY		MENTAL HISTORY		SUBSTANCE ABUSE		Tobacco		Alcohol		Drugs		Other	
PREVIOUS ILLNESSES		SURGICAL HISTORY		TRAUMA		INJURY		POISONING		SUFFOCATION		SIGNATURE OF EXAMINER		DATE		TIME	
MORBID ANATOMY		GROSS PATHOLOGY		MICROSCOPIC PATHOLOGY		IMMUNOHISTOCHEMISTRY		CYTOLOGY		MOLECULAR BIOLOGY		SIGNATURE OF EXAMINER		DATE		TIME	

BUREAU V. 2

MAR 18 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial/transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02833

02823

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Charles</u>	<u>MARYLAND</u>	STATE <u>Maryland</u>	COUNTY <u>Charles</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>La Plata</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>La Plata</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Florence</u> (Middle) <u>Jenifer</u> (Last) <u>Mitchell</u>		(Month) <u>3</u> (Day) <u>2</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 7, 1868</u>
9. AGE last birthday <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Daniel Jenifer</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Risteor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>James C. Mitchell La Plata, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
525X IMMEDIATE CAUSE (A) <u>General Visceral Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Fibrosis of Lungs</u>		<u>4 Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 42</u> , to <u>3-2-</u> , <u>19 57</u> , that I last saw the deceased alive on <u>3-1</u> , <u>19 57</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>E. Roden</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 4, 1957</u>	
24. REC'D BY REGISTRAR <u>Julia Posey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home Waldorf, Md.</u>	
DATE <u>MAR 5 1957</u>		ADDRESS (Street, city, town, state)	

CERTIFICATE OF DEATH

RECEIVED STATE DEPARTMENT OF HEALTH - BALTIMORE

FILE NO.

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

STATE

CITY

CAUSE OF DEATH

IMMEDIATE CAUSE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. S.

MAR 5 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02834	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 101	
1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oranburg</i>			c. LENGTH OF STAY IN 1b <i>50 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Oranburg</i>			d. STREET ADDRESS <i>1</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Henry</i> Last <i>Mitchell</i>					4. DATE OF DEATH Month <i>March</i> Day <i>26</i> Year <i>1957</i>						
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 3, 1888</i>		9. AGE (in years last birthday) <i>69 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Powder Worker</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Naval Powder Factory</i>			11. BIRTHPLACE (State or foreign country) <i>Parkersburg, Virginia</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>John Childs Mitchell</i>					14. MOTHER'S MAIDEN NAME <i>Ellie Alsop</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Mrs. Harold Warden Indian Head, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inhalation Carbon Monoxide</i> <i>891.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>Not known</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Body was found and inclosed garage by exhaust of car</i>								
20c. TIME OF INJURY Month, Day, Year <i>8 Hour a.m. March 26 1957</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>			20f. (City or town) <i>Oranburg</i> (County) <i>Charles</i> (State) <i>Md</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Frank A. Susan</i>					M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) <i>Frank A. Susan M.D.</i>					DATE SIGNED <i>3-26-57</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			22b. DATE THEREOF <i>3-29-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Chesapeake Methodist</i>			22d. LOCATION (City, town, or county) <i>Chesapeake Md</i> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Honitt Funeral Home - Waldorf, Md</i> ADDRESS						24a. REC'D BY REGISTRAR <i>Mary Southland</i> DATE <i>MAR 29 1957</i>			24b. REGISTRAR'S SIGNATURE		

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM EXAMINATION	
SIGNATURE OF MEDICAL EXAMINER		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF CORONER		DATE		TIME		PLACE		CITY		STATE	

BUREAU V. S.

MAR 29 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02835

02825

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Marbury</u>		LENGTH OF STAY (in this place) <u>1 yr</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Marbury</u>		TOWN <u>Marbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>Flottie</u> (First) <u>Lee</u> (Middle) <u>Pribble</u> (Last)				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>31</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>March 31, 1882</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Campbell County, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Lewis Arthur</u>				14. MOTHER'S MAIDEN NAME <u>Sally Womack</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S ADDRESS <u>Mrs. Vernon Hudson, Marbury, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 10, 1956</u>, to <u>March 31, 1957</u>, that I last saw the deceased alive on <u>3/31/57</u>, 19<u>57</u>, and that death occurred at <u>12:30 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Frank A. Susan</u> M.D.				ADDRESS (Street, city, town, state) <u>Indian Head, Md</u>			
DATE SIGNED <u>3-31-57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/1/57</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Hill</u>		LOCATION (City, town, or county) (State) <u>Lynchburg, Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Julius H. Pacey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Luc Laplante</u>			
DATE <u>4/1/57</u>							

BUREAU V. S.

APR 3 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02836

02826

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>CHARLES</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HUGHESVILLE</u>		<u>LIFE</u>		TOWN <u>HUGHESVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. #5</u>				STREET ADDRESS (If rural give location) <u>Rt. #5</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ELMER</u> (Middle) <u>M</u> (Last) <u>QUADE</u>				(Month) <u>MARCH</u> (Day) <u>18</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>MALE</u>	<u>WHITE-US</u>	<u>MARRIED</u>	<u>FEBRUARY 27, 1900</u>	<u>57</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>AUTOMOTIVE DEALER</u>		<u>AUTOMOTIVE</u>		<u>MARYLAND</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>STEVEN QUADE</u>				<u>Jella B Roby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>21301-2454</u>		<u>Rosale Quade</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS, ACUTE</u>						<u>10 MINUTES</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY THROMBOSIS, RECOVERING</u>						<u>60 DAYS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>DECEMBER 19, 1948</u> , to <u>MARCH 18, 1957</u> , that I last saw the deceased alive on <u>MARCH 18, 1957</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>John H. Griffin</u> M.D.				<u>Box #65 HUGHESVILLE MD.</u>		<u>3/18/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>3-21-57</u>		<u>Oldfield</u>		<u>Oldfield md. Charles CO</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>3/21/57</u>		<u>Julius H. Parry</u>		<u>Archant 2nc</u>		<u>Lopata md.</u>	

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72.4** hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1.55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02827 CERTIFICATE OF DEATH

02837

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Charles	STATE	Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL OR end give nearest town)	BEL ALTON	CITY (If outside corporate limits, write RURAL and give nearest town)	BEL ALTON
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
John E. WELCH		MARCH 22 1957	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
M	W	MARRIED	July 1877
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
79 yrs.		USA	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Charles Co. Md.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Edmond WELCH		Josephine SWANN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
No			
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
Herman Welch SPRING HILL, MD.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
203X IMMEDIATE CAUSE (A)		3 mos	
ANTECEDENT CAUSE(S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)			
19. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. HOW DID INJURY OCCUR?	
21f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from 25 DEC 1956 to 22 MAR 1957, that I last saw the deceased alive on 21 MAR 1957, and that death occurred at 11:30 PM from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
J. J. Williams M.D.		3-24-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR	
Burial		MAR 26 1957	
DATE THEREOF		25. FUNERAL DIRECTOR'S SIGNATURE	
3-25-57		The Hunt Funeral Home	
NAME OF CEMETERY OR CREMATORY		ADDRESS	
St Ignatius		La Plata, Md.	
LOCATION (City, town, or county)		Chapel Point Md.	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. DECEASED'S NAME (Last, first, middle)

2. SEX

3. RACE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. US BIRTH

9. DATE OF DEATH

10. PLACE OF DEATH

11. CAUSE OF DEATH

12. MEDICAL EXAMINATION

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESS

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF CLERK

17. SIGNATURE OF JUDGE

18. SIGNATURE OF NOTARY

19. SIGNATURE OF DECEASED

20. SIGNATURE OF WITNESS

21. SIGNATURE OF PHYSICIAN

22. SIGNATURE OF CLERK

23. SIGNATURE OF JUDGE

24. SIGNATURE OF NOTARY

25. SIGNATURE OF DECEASED

26. SIGNATURE OF WITNESS

27. SIGNATURE OF PHYSICIAN

28. SIGNATURE OF CLERK

29. SIGNATURE OF JUDGE

30. SIGNATURE OF NOTARY

31. SIGNATURE OF DECEASED

32. SIGNATURE OF WITNESS

33. SIGNATURE OF PHYSICIAN

34. SIGNATURE OF CLERK

35. SIGNATURE OF JUDGE

36. SIGNATURE OF NOTARY

37. SIGNATURE OF DECEASED

38. SIGNATURE OF WITNESS

39. SIGNATURE OF PHYSICIAN

40. SIGNATURE OF CLERK

41. SIGNATURE OF JUDGE

42. SIGNATURE OF NOTARY

43. SIGNATURE OF DECEASED

44. SIGNATURE OF WITNESS

45. SIGNATURE OF PHYSICIAN

46. SIGNATURE OF CLERK

47. SIGNATURE OF JUDGE

48. SIGNATURE OF NOTARY

49. SIGNATURE OF DECEASED

50. SIGNATURE OF WITNESS

51. SIGNATURE OF PHYSICIAN

52. SIGNATURE OF CLERK

53. SIGNATURE OF JUDGE

54. SIGNATURE OF NOTARY

55. SIGNATURE OF DECEASED

56. SIGNATURE OF WITNESS

57. SIGNATURE OF PHYSICIAN

58. SIGNATURE OF CLERK

59. SIGNATURE OF JUDGE

60. SIGNATURE OF NOTARY

61. SIGNATURE OF DECEASED

62. SIGNATURE OF WITNESS

63. SIGNATURE OF PHYSICIAN

64. SIGNATURE OF CLERK

65. SIGNATURE OF JUDGE

66. SIGNATURE OF NOTARY

67. SIGNATURE OF DECEASED

68. SIGNATURE OF WITNESS

69. SIGNATURE OF PHYSICIAN

70. SIGNATURE OF CLERK

71. SIGNATURE OF JUDGE

72. SIGNATURE OF NOTARY

73. SIGNATURE OF DECEASED

74. SIGNATURE OF WITNESS

75. SIGNATURE OF PHYSICIAN

76. SIGNATURE OF CLERK

77. SIGNATURE OF JUDGE

78. SIGNATURE OF NOTARY

79. SIGNATURE OF DECEASED

80. SIGNATURE OF WITNESS

81. SIGNATURE OF PHYSICIAN

82. SIGNATURE OF CLERK

83. SIGNATURE OF JUDGE

84. SIGNATURE OF NOTARY

85. SIGNATURE OF DECEASED

86. SIGNATURE OF WITNESS

87. SIGNATURE OF PHYSICIAN

88. SIGNATURE OF CLERK

89. SIGNATURE OF JUDGE

90. SIGNATURE OF NOTARY

91. SIGNATURE OF DECEASED

92. SIGNATURE OF WITNESS

93. SIGNATURE OF PHYSICIAN

94. SIGNATURE OF CLERK

95. SIGNATURE OF JUDGE

96. SIGNATURE OF NOTARY

97. SIGNATURE OF DECEASED

98. SIGNATURE OF WITNESS

99. SIGNATURE OF PHYSICIAN

100. SIGNATURE OF CLERK

101. SIGNATURE OF JUDGE

102. SIGNATURE OF NOTARY

103. SIGNATURE OF DECEASED

104. SIGNATURE OF WITNESS

105. SIGNATURE OF PHYSICIAN

106. SIGNATURE OF CLERK

107. SIGNATURE OF JUDGE

108. SIGNATURE OF NOTARY

109. SIGNATURE OF DECEASED

110. SIGNATURE OF WITNESS

111. SIGNATURE OF PHYSICIAN

112. SIGNATURE OF CLERK

113. SIGNATURE OF JUDGE

114. SIGNATURE OF NOTARY

115. SIGNATURE OF DECEASED

116. SIGNATURE OF WITNESS

117. SIGNATURE OF PHYSICIAN

118. SIGNATURE OF CLERK

119. SIGNATURE OF JUDGE

120. SIGNATURE OF NOTARY

121. SIGNATURE OF DECEASED

122. SIGNATURE OF WITNESS

123. SIGNATURE OF PHYSICIAN

124. SIGNATURE OF CLERK

125. SIGNATURE OF JUDGE

126. SIGNATURE OF NOTARY

127. SIGNATURE OF DECEASED

128. SIGNATURE OF WITNESS

129. SIGNATURE OF PHYSICIAN

130. SIGNATURE OF CLERK

131. SIGNATURE OF JUDGE

132. SIGNATURE OF NOTARY

133. SIGNATURE OF DECEASED

134. SIGNATURE OF WITNESS

135. SIGNATURE OF PHYSICIAN

136. SIGNATURE OF CLERK

137. SIGNATURE OF JUDGE

138. SIGNATURE OF NOTARY

139. SIGNATURE OF DECEASED

140. SIGNATURE OF WITNESS

141. SIGNATURE OF PHYSICIAN

142. SIGNATURE OF CLERK

143. SIGNATURE OF JUDGE

144. SIGNATURE OF NOTARY

145. SIGNATURE OF DECEASED

146. SIGNATURE OF WITNESS

147. SIGNATURE OF PHYSICIAN

148. SIGNATURE OF CLERK

149. SIGNATURE OF JUDGE

150. SIGNATURE OF NOTARY

151. SIGNATURE OF DECEASED

152. SIGNATURE OF WITNESS

153. SIGNATURE OF PHYSICIAN

154. SIGNATURE OF CLERK

155. SIGNATURE OF JUDGE

156. SIGNATURE OF NOTARY

157. SIGNATURE OF DECEASED

158. SIGNATURE OF WITNESS

159. SIGNATURE OF PHYSICIAN

160. SIGNATURE OF CLERK

161. SIGNATURE OF JUDGE

162. SIGNATURE OF NOTARY

163. SIGNATURE OF DECEASED

164. SIGNATURE OF WITNESS

165. SIGNATURE OF PHYSICIAN

166. SIGNATURE OF CLERK

167. SIGNATURE OF JUDGE

168. SIGNATURE OF NOTARY

169. SIGNATURE OF DECEASED

170. SIGNATURE OF WITNESS

171. SIGNATURE OF PHYSICIAN

172. SIGNATURE OF CLERK

173. SIGNATURE OF JUDGE

174. SIGNATURE OF NOTARY

175. SIGNATURE OF DECEASED

176. SIGNATURE OF WITNESS

177. SIGNATURE OF PHYSICIAN

178. SIGNATURE OF CLERK

179. SIGNATURE OF JUDGE

180. SIGNATURE OF NOTARY

181. SIGNATURE OF DECEASED

182. SIGNATURE OF WITNESS

183. SIGNATURE OF PHYSICIAN

184. SIGNATURE OF CLERK

185. SIGNATURE OF JUDGE

186. SIGNATURE OF NOTARY

187. SIGNATURE OF DECEASED

188. SIGNATURE OF WITNESS

189. SIGNATURE OF PHYSICIAN

190. SIGNATURE OF CLERK

191. SIGNATURE OF JUDGE

192. SIGNATURE OF NOTARY

193. SIGNATURE OF DECEASED

194. SIGNATURE OF WITNESS

195. SIGNATURE OF PHYSICIAN

196. SIGNATURE OF CLERK

197. SIGNATURE OF JUDGE

198. SIGNATURE OF NOTARY

199. SIGNATURE OF DECEASED

200. SIGNATURE OF WITNESS

201. SIGNATURE OF PHYSICIAN

202. SIGNATURE OF CLERK

203. SIGNATURE OF JUDGE

204. SIGNATURE OF NOTARY

205. SIGNATURE OF DECEASED

206. SIGNATURE OF WITNESS

207. SIGNATURE OF PHYSICIAN

208. SIGNATURE OF CLERK

209. SIGNATURE OF JUDGE

210. SIGNATURE OF NOTARY

211. SIGNATURE OF DECEASED

212. SIGNATURE OF WITNESS

213. SIGNATURE OF PHYSICIAN

214. SIGNATURE OF CLERK

215. SIGNATURE OF JUDGE

216. SIGNATURE OF NOTARY

217. SIGNATURE OF DECEASED

218. SIGNATURE OF WITNESS

219. SIGNATURE OF PHYSICIAN

220. SIGNATURE OF CLERK

221. SIGNATURE OF JUDGE

222. SIGNATURE OF NOTARY

223. SIGNATURE OF DECEASED

224. SIGNATURE OF WITNESS

225. SIGNATURE OF PHYSICIAN

226. SIGNATURE OF CLERK

227. SIGNATURE OF JUDGE

228. SIGNATURE OF NOTARY

229. SIGNATURE OF DECEASED

230. SIGNATURE OF WITNESS

231. SIGNATURE OF PHYSICIAN

232. SIGNATURE OF CLERK

233. SIGNATURE OF JUDGE

234. SIGNATURE OF NOTARY

235. SIGNATURE OF DECEASED

236. SIGNATURE OF WITNESS

237. SIGNATURE OF PHYSICIAN

238. SIGNATURE OF CLERK

239. SIGNATURE OF JUDGE

240. SIGNATURE OF NOTARY

241. SIGNATURE OF DECEASED

242. SIGNATURE OF WITNESS

243. SIGNATURE OF PHYSICIAN

244. SIGNATURE OF CLERK

245. SIGNATURE OF JUDGE

246. SIGNATURE OF NOTARY

247. SIGNATURE OF DECEASED

248. SIGNATURE OF WITNESS

249. SIGNATURE OF PHYSICIAN

250. SIGNATURE OF CLERK

251. SIGNATURE OF JUDGE

252. SIGNATURE OF NOTARY

253. SIGNATURE OF DECEASED

254. SIGNATURE OF WITNESS

255. SIGNATURE OF PHYSICIAN

256. SIGNATURE OF CLERK

257. SIGNATURE OF JUDGE

258. SIGNATURE OF NOTARY

259. SIGNATURE OF DECEASED

260. SIGNATURE OF WITNESS

261. SIGNATURE OF PHYSICIAN

</

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02828

CERTIFICATE OF DEATH

02838

Reg. Dist. No.

105

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>xo Waldorf</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Dora</i> Middle <i>Wood</i> Last <i>Wood</i>		4. DATE OF DEATH Month <i>March</i> Day <i>2</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 19, 1890</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Ellwood Roberts</i>		14. MOTHER'S MAIDEN NAME <i>Adeline Hall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>27-102101</i>	
17. INFORMANT <i>Lee Wood</i> Address <i>Waldorf, MD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Cancer of eye</i> 192x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 3</i> , 19 <i>57</i> , to <i>March 2</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Feb. 28</i> , 19 <i>57</i> , and that death occurred at <i>9:45 P.</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Rune H. Dobson</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>Brandenburg, Md.</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremated</i>		22b. DATE THEREOF <i>March 4, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Oakland</i>		22d. LOCATION (City, town, or county) (State) <i>Waldorf MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home</i> ADDRESS <i>Waldorf, Md.</i>		24a. REC'D BY REGISTRAR <i>Miss M.L. Murray</i> DATE <i>MAR 5 1957</i>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		1957		NEW YORK	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS	
HEART DISEASE		NATURAL		SEAMAN		HIGH SCHOOL		METHODIST		MARRIED	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO COUNTRY		DATE OF LAST ENTRY INTO COUNTRY		DATE OF LAST ENTRY INTO COUNTRY		DATE OF LAST ENTRY INTO COUNTRY	
1912		NEW YORK		1935		1935		1935		1935	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1957		NEW YORK		1957		NEW YORK		1957		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1957		NEW YORK		1957		NEW YORK		1957		NEW YORK	

RECEIVED
MAR 5 1957
BUREAU V. S.

100-121040

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02829

CERTIFICATE OF DEATH

02839

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>CHARLES</u>	STATE <u>MARYLAND</u>	STATE <u>N.J.</u>	COUNTY <u>✓</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>LAPLATA.</u>	LENGTH OF STAY (In this place) <u>12 hrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodstown</u>	<u>67x3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial</u>	STREET ADDRESS <u>112 N. Mainstreet.</u>	(If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>ROY</u> (Middle) <u>C</u> (Last) <u>WOOLMAN</u>		(Month) <u>March</u> (Day) <u>25</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>3 April 1881</u>
9. AGE last birthday <u>75</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>N.J.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Howard T. Woolman</u>	
14. MOTHER'S MAIDEN NAME <u>Ella Clarke</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>My William Freese</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		420.1 IMMEDIATE CAUSE (A) <u>Respiratory failure</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary occlusion</u>		24 hrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>diabetes.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>23 Mar., 1957</u> , to <u>25 Mar., 1957</u> , that I last saw the deceased alive on <u>25 March 1957</u> , and that death occurred at <u>6:30 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Howard D. M.D.</u>		DATE SIGNED <u>LaPlata, Md. 25 Mar 57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>3/27/57</u>	
NAME OF CEMETERY OR CREMATORY <u>Clarksville</u>		LOCATION (City, town, or county) (State) <u>Woodstown N.J.</u>	
24. REC'D BY REGISTRAR <u>Julia H. Pacey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Orknot Inc LaPlata Md</u>	
DATE <u>3/26/57</u>		ADDRESS	

CERTIFICATE OF DEATH

Reg. No. 1234

1. DECEASED'S NAME (Print or Write)

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MEDICAL CERTIFICATE

BUREAU V. 1

MAR 28 1957

RECEIVED

CERTIFICATE